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ABSTRACT

This paper describes a child/parent center for mothers and preschoolers, the Child in the City Programme, which was developed at the University of Toronto. First, the context within which the center was developed is presented: The neighborhood in which the center is located is considered high risk because of the great degree of social isolation: social services have not been successful in the area: and government policy recognized the need for developing alternative social support systems like the center. Next, the center itself is described. The two-stage program emphasizes the provision of support for mothers of young children so they can take advantage of opportunities outside their homes. The center also has staff to support other efforts to provide services to parents. The final section of this paper reports on a pilot evaluation of the program. Data were collected through interviews with mothers who were participating in the program. The findings indicated that some objectives of the program are being met effectively. Positive changes in mental health, physical health, and amount of participation in the community by mothers increased as length of time in contact with the center increased. Tables of data are appended. (MK)

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BUILDING INFORMAL SUPPORT NETWORKS FOR PARENTS IN A HIGH RISK COMMUNITY

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INTRODUCTION[1]

As Dr. Newborough indicated in his opening remarks, one of the purposes of the Child in the City Programme at the University of Toronto is to increase our understanding of preventive interventions. This derives from our funder's, the Hospital for Sick Children, interest in reaching beyond the hospital walls to children where they are at risk, that is, in their own neighbourhoods. As a consequence, I have become involved in evaluating the effectiveness of a child/parent centre for mothers and pre-schoolers. The Centre was developed by residents in a high risk area of Toronto with the help of a community worker, provided by the Children's Aid Society, to provide supports to parents living in the area. Discussion with the participants at the Centre suggested that the model implemented there would, if successful, not only have a preventive impact, but also had some innovative components worth examining more fully. At this stage, we have some pilot data which suggest that the Centre is being effective, and we are, therefore, pursuing funding for a more comprehensive evaluation of the model. What I would like to do today is give a progress report.

What I will do in this paper is 1) try to set a context within which to consider the model at the Centre, 2) describe the basic thrust of the model and, 3) present some of the pilot data; all briefly. Before proceeding, I must say that the ideas presented here reflect a close collaboration with the staff and the community residents involved at the Centre both as users and board members. This process has been very exciting for me.

CONTEXT OF THE CHILD/PARENT CENTRE

High Risk Neighbourhood

It has been suggested in the literature that stressful life events and life conditions are negatively related to well-being. To mention only a few findings, level of stress as estimated through a survey of life events and conditions, has been found to correlate with general measures of psychiatric impairment (Andrews et al., 1978; Myers et al., 1972), depression (Belle et al., 1978; Pearlin and Johnson, 1977) and a range of physical illnesses, for children as well as adults (Gersten et al., 1974; Heisel et al., 1973; Rabkin and Streuning, 1978). While many of the studies have been the subject of

methodological criticism (see e.g. Rabkin and Struning, 1976), recent work responding to the criticism confirms the earlier pattern. For example, while in the early work studies failed to clearly establish the direction of the effect, that is, whether sufficient stress preceded the illness as opposed to resulting from it in order to conclude that the stress had a causal role, recent work is establishing the causal role of stress in life circumstances more firmly, e.g. by examining on-going life conditions (Belle et al., 1978) and by using time series analyses (Eaton, 1978).

A second finding is that among individuals living highly stressed lives those who are isolated are more at risk than those who have social support (Andrews et al., 1978b; Kaplan et al, 1978; Nuchols et al., 1972). In other words, social isolation is a compounding factor, either because it adds directly to stress and/or because a protective function of social support in dealing with stress is not available to the isolated individual (Longfellow, 1979).

Importantly, in terms of our interest in children, isolation seems to affect parenting adversely as well. Relatively isolated parents have been found to be less responsive to their children (Longfellow, 1979; Minde et al., 1978), and in extreme cases have been found to be more likely to be child abusers (Garbarino, 1976; 1977). It seems that the availability of social supports, though the kind of support varies in these studies, has been shown to be an important influence on the quality of parenting.

How does the area of Toronto we are talking about look in terms of these findings. The area has the second largest amount of government subsidized housing in a Metro Toronto neighbourhood, some with a high density of single mothers. Therefore for many the stress of poverty is combined with that of single parenthood. The area is also characterized by a high mobility, with a high proportion of recent immigrants relative to other areas. The pattern emerging from these facts suggests that the area relative to others in Toronto has a population whose life conditions are stressful.

In terms of isolation, some of the same factors already mentioned contribute to isolation as well. For example, single parents have fewer supports than married ones (Hetherington, 1976; Pearlin and Johnson, 1977). Many immigrants, at least for a period of time, are separated from the supports they are

accustomed to. In addition, the pilot data suggest that high mobility in a neighbourhood can itself be a contributing factor. Table 1 shows the number of close friends users of the Child/Parent Centre report by their length of residence in the area. The relationship may be curvilinear. Women develop a few close friendships when they come to the area. However, the number of close friends they report drops off after they have been in the area for a while (3-5 years) and then seems to begin to go up again with continuing residence in the area. Residents in the area offer the following explanation: newcomers identify people as close friends who are not, in order to deal with the loneliness that they experience on moving to the area. After a period of time, they develop a group of "close friends" but these friends often move away for a variety of reasons. People having experienced the hurt of losing their friends and expecting that it will happen again are less likely to risk forming close friendships. The result is relative isolation among people who have lived in the area for a number of years. Then gradually, the need for friendship mobilizes the women to once again take the risk of forming close friendships.[2] The implication of these data is that geographic mobility results in isolation not only for those who move but also for those who stay behind.

There are other factors which contribute to the isolation that people report. The way in which this community has been developed seems to have compounded the factors already enumerated. The area has been characterized by rapid growth. The neighbourhood is located in a District of Metro Toronto where the population increased from 5,995 in 1951 to 111,550 in 1976 (Novick, 1979). Adequate housing has been provided for the large influx of people. However, the development plan has not adequately taken into account the need to provide supports for the social cohesion of the community to develop. Because it is a relatively new community, there are not social institutions of long standing which can bring people together, as there are in many older communities (Novick, 1979). In addition, the area does not have a lot of places to chat informally and the policies governing the use of those which do exist seem to interfere with informal and exploratory social contacts. For example, according to residents, Ontario Housing provides a meeting room in its high rises. However, the room is locked and residents can gain access only for purposes which will benefit recognized groups. This is something of a

"Catch-22." People are isolated and need a place to meet each other. A place exists where they could meet each other, but they cannot use it until they are in some way related to a group. So it often sits empty. The policy as to the use of the Community Centres in the area is similar, and in this case expensive facilities are not fully utilized.

The area also shares in the phenomenon Warren (1963) has argued characterizes modern communities in general. He suggests that we have come to rely on large non-community based organizations to take care of our basic needs, in the interests of efficiency and sometimes equity. This applies to any number of areas in our lives, including the provision of food, heat, sewage and services like day care, child protection and so on. The consequence is that the community is less of an interdependent and self-sufficient unit. There are fewer opportunities for cooperative efforts to arise among community members out of shared interests and a sense of responsibility for taking care of themselves. This, then, is another source of relative isolation. People have fewer opportunities to work together to meet their needs.

In summary, these patterns and the personal accounts of users of the Centre suggest considerable isolation exists in the area. While it remains to document the extent and origins of the isolation in the area more precisely, these accounts are suggestive. The consequences of isolation as it has evolved in this area are likely to be twofold: the individual is more at risk of illness on a personal level, and the community as a context within which people can take responsibility for their own lives is lacking in relative terms.

The Traditional Case Method

It would seem in examining the spectrum of social services available and the training of the people who staff them that the traditional response in situations such as these, one of treatment for individuals after a problem emerges, continues to be the prevalent one (Davies, 1977; Dohrenwend, 1978). But, interestingly, with a slight twist on a familiar theme, treating individuals can be viewed as dealing with the symptoms of the problem and not the problem itself. Treatment of individuals is not in and of itself likely to alter the situation which gives rise to or at the minimum contributes to the problems requiring treatment.

Policy Context

There is concern in Ontario, as elsewhere, about the cost of the traditional mode of intervention. The concern has given rise to a search for alternatives. The Ministry of Community and Social Services in Ontario is pursuing a policy of de-institutionalization. And a recent provincial policy paper in Ontario, once again, emphasizes the responsibility of the family unit for meeting its basic needs with critical support assumed to come from the community. However, in this case, community is represented by voluntary organizations and not the informal, natural supports of neighbours and friends. (Birch, 1975).

The justaposition of the policies of de-institutionalization and an emphasis on family responsibility is a cause for concern. The experience in the United States with the community mental health movement and local experience suggest that the stress on families of caring for members who are acutely or chronically ill is considerable (Arnhoff, 1975; Hagarty and Hagarty, 1977). The justaposition is particularly a cause for concern in areas like the one described. Based on the previous analysis, returning responsibility to the family will mean returning it disproportionately often to those families who are isolated and who lack the resources to deal with it, because social isolation is related to illness, having special needs and to already living under stressful conditions.

This suggests that what is needed is an intervention which develops informal social supports in the community, because developing social support deals directly with a part of the situation in the community which contributes to some of the problems requiring treatment and, in addition, it can strengthen the resilience of the community for dealing with other problems encountered by its members. The Child/Parent Centre is such an intervention and is being funded by the Ministry of Community and Social Services in its attempt to find alternatives to traditional services which will have a preventive impact.

THE CHILD/PARENT CENTRE

The objectives of the Child/Parent Centre in supporting non-working mothers with pre-schoolers are

1) to increase the social support available to them,

2) to enhance their sense of personal effectiveness, and

3) to intervene such that the benefits of the Centre diffuse beyond users to the parents in the community at large.

In order to accomplish its objectives, the Child/Parent Centre has implemented a process, which has two stages, described respectively as catalyst and resource. It is beyond the scope of this paper to detail the programmes of the Centre which are based on this process. Therefore, the Child/Parent Drop-In has been selected to exemplify the way in which the Centre works.

The Child/Parent Drop-In

The Site: The Centre has furnished a room as a Child/Parent Drop-In where parents come with their pre-school children any or all of two mornings a week. There are a range of toys and materials for children at the Drop-In, and there is a comfortable space for mothers to talk within sight of their children. It is an unstructured setting, with two staff available to spend time with mothers and children as needed. While unstructured, it is set up to provide a variety of opportunities, which mothers take advantage of at their own pace. Mothers can meet other mothers. They can share problems with other mothers who are similar to them. They can learn about parenting by seeing staff interact with their children or by reading the available materials. They can get information both about local services and community activities for themselves and their children. In other words, the Drop-In is a place to go to take a break, to talk with other mothers, to get help with a problem, to learn about parenting, to gain access to other resources in the community, and more.

These are the opportunities provided by the Drop-In. Understanding how the Centre works with these opportunities, making them a support to parents some of whom are "hard to reach", requires a closer look at the model implemented at the Centre.

Stage 1: Catalyst for Change: A mother who comes to the Drop-In may not be ready or able to take advantage of the opportunities the Centre provides. Therefore, when necessary staff encourage and support mothers in developing the

skills and the self-confidence needed to take advantage of opportunities. To elaborate, for some mothers, who spend most of their time in their homes with their children, just coming to the Centre is an important first step. It is assumed that gradually, in a non-threatening atmosphere, the mother will begin to feel comfortable joining others talking about concerns and problems. When she does the staff are to respond themselves and to encourage other mothers to respond, by listening, and making suggestions, or by actually assisting the mother with the situation which is troubling her when such support seems wanted. Assuming that this support helps the mother solve the problem or feel better about the situation, it is likely that she will gain confidence both in herself as able to do something for herself and in the support available to her. As involvement in the Drop-In continues, staff are to support the mother in her efforts to respond to the needs of other mothers. This experience of providing support to others, if positive, again contributes to a sense of worth and effectiveness.

Importantly, the contacts mothers make with each other at the Drop-In become personal support systems, involving for example emergency child care, short term loans, advice, help or support in dealing with an agency and so on. As these relationships develop, the actual physical setting of the Drop-In gradually decreases in importance, even though the mothers may still be in contact with the Drop-In or the Centre. In other words, the support becomes independent of the Drop-In.

It is assumed that as the mother gains confidence in her effectiveness, both on behalf of herself and others, and in the informal support available to her, she will have the necessary base of security from which to take advantage of the range of opportunities in the community that can be accessed through the Centre. Therefore, at this point the mother is encouraged to become involved in other community activities. The objectives of this involvement are at first to expand the range of settings in which the mother has experience and feels confident. Then the mother is encouraged and supported in the process of taking on "responsibilities" in the various activities in which she becomes involved, which may include starting up needed resources. Involvement has, in the past, included sitting on the Child/Parent Committee which is the community board of the Child/Parent Centre, starting a nursery school and starting a

baby-sitting co-op. It is assumed that, if successful, this process of involvement in the community will not only benefit the individual mother by enhancing her sense of self-worth and efficacy, but will also benefit the community through the development of needed resources and the creation of a base of community residents who have experience in identifying and responding to the needs of parents in the community at large.

An observation about this process is offered by way of a summary of this phase of the intervention as a catalyst. Dependency on the Centre is intended to be a short-term state. The Centre, helps parents build a sense of self-confidence in themselves and in the support of others. The Centre's success is measured in part in terms of the extent to which users develop support systems which function independently of the Drop-In and in part in terms of extent to which the base of security developed or reaffirmed enables a parent to become involved in and take on responsibility for other activities in the community with an emphasis on activities relating to parenting. While a mother may keep in contact with the Centre throughout this process and beyond, the contact is assumed to involve increasing use of the Centre as a facilitative resource (see following section) rather than continuing an intensive use of the Centre as a personal support. As a consequence the Centre's resources, as catalyst, are freed up to begin the process with new users.

Stage 2: Facilitative Resource for Parents: The first stage of the intervention provides support to mothers who come to the Centre as individuals. In the second stage the staff provide support to individuals or groups who are devoting their time and effort to developing "programmes" needed by parents with children in the community. The Centre's help can vary from doing typing or providing information to consulting or providing transitional staffing. Whatever the level of involvement, the intention is to help the parents respond effectively to a need they have identified. The Centre is a facilitative resource. The initiative and the responsibility for the follow-through are the parents. Without the parents the need will not be met.

Diffusion: The benefits of contact with the Centre are likely to diffuse well beyond those who use it, because users become informal resources to the community in several different ways. They are part of an activated network of

informal support available to parents in the community. They are involved in developing programmes which respond to their needs as parents, which will benefit not only themselves but also others in the community. And finally, as their experience accumulates they become a resource to the community in terms of identifying, planning for and meeting parent's and children's needs; persons to whom others can turn in their efforts.

PILOT DATA

There are some data available relevant to the effectiveness of the Centre, from a pilot of a 4-hour interview with 26 mothers who had come to the Centre. All the mothers who had come to the Child/Parent Drop-In from January, 1978 through February, 1979 were contacted. Twenty-six (81%) agreed to be interviewed.

Data are available as to the length of time a mother has been in contact with the Centre for 16 of the women. Should these women differ on selected measures, in the expected direction, as their length of contact with the Centre increases, it will be assumed here that the differences may reflect the effects of the Centre. Without pre-post contact data and a control group, it is not possible to be at all certain that contact with the Centre changes the mothers' or their childrens' lives, but it is a beginning.

The pilot data do suggest that the Centre may be being effective in reaching some of its objectives. The data in Table 2 indicate that as length of contact with the Centre increases the number of close friends the mother reports increases. (Close friends refers to people the respondent feels she can turn to and can be herself with). These data do conform with the Centre's intention of increasing the informal supports available to its users.

The data in Table 2 also indicate that perceived locus of control varies with length of contact with the Centre. However, this finding is in the opposite of the expected direction on two of three subscales in that mothers who have been in contact with the Centre longer are more external. With increasing contact with the Centre they may be becoming more external in terms of impulse control suggesting they feel less in control of their emotions. And the women seem to perceive the social system, that is the political system and the like, to be less within their control as the length of contact with

with the Centre increases. Other women at the Centre feel both these findings are plausible in that as a woman is at the Centre longer she may become more aware of her insecurity, her anger and other feelings and that this gets somewhat out of control at times during the process of personal growth. With respect to the social system, these women suggest that it is currently outside their control and recognizing this is a first step in deciding what to do. These findings need to be followed up, and if replicated, it will be important to assess their implications for mothers effectiveness in their chosen activities. Perhaps they will be more effective. Perhaps less.

The date in Table 2 indicate that the number of activities in which mothers and to some extent children are involved in the community varies significantly with the length of their contact with the Centre. Similarly, the level of responsibility mothers take in the activities they are involved in increases as length of contact with the Centre increases. This suggests the Centre may be being effective in accomplishing this objective as well.

Finally, although not specified as an objective, it was assumed that increasing the social support available to mothers and increasing their sense of their own effectiveness would have preventive value for the family. The data in Table 2 indicate that the extent of depression reported "in the last week" does not vary with increasing contact with the Centre. However since the scale was placed at the end of the first 2 hour session the data could reflect the content of the session. Since the level of depression was quite high among these women it is important to find the correct interpretation. It would be of considerable interest if support were not affecting depression, particularly in light of the next findings to be discussed.

The data in Tables 3 - 5 suggest that the physical health of the mothers and their preschoolers may be improving as their length of contact with the Centre increases. The mothers were asked to discuss up to two illnesses and two accidents for each adult and preschool child in their family in the past year, starting with the most serious. Mothers who had been at the Centre for a shorter period of time (7 months or less) were more frequently ill than mothers who have been there a while (Table 3). The new mothers are 44% of the sample, but account for 76% of the illnesses.

And while newer mothers do not report more accidents they seem to be more frequently incapacitated by the combination of illnesses and accidents they do have. This is suggested by the fact that they contact the doctor and are hospitalized for a higher percentage of their illnesses and accidents than mothers who have been in contact with the Centre longer. Similarly, the pre-school children of mothers who have been at the Centre for a shorter period of time are more frequently ill, have more accidents and more of their illnesses and accidents seem to be serious than those of mothers and pre-school children who have been there longer. The one place in Table 4 that is inconsistent with this description shows that mothers who have been at the Centre longer contact the doctor for as many of their children's illnesses and accidents as newer mothers. It is quite possible that this reflects a tendency for mothers to call a doctor more readily about children's illnesses whether or not they are serious, and not that the illnesses in both groups are equally serious, (especially in the context of the hospitalization data).

While the Centre may be having a preventive impact on mothers and their pre-school children, the effect does not appear to be spreading to their spouses (Table 5). Spouses of the women are equally ill. Spouses of women who have been there longer may be having more accidents than spouses of newer mothers and not the reverse. And the illnesses and accidents seem equally serious, not less serious for spouses of women who have been there longer.

The possibility that the Centre is benefiting mothers and pre-schoolers but not spouses needs looking into. But for the time being these data as to its possible preventive value are very encouraging.

More thorough analyses of these data and a follow up study are planned. For the moment, the data suggest that it is worth exploring interventions whose objectives include increasing the informal social support available to mothers, because they may have preventive value. In addition to elaborating on these findings, efforts to go beyond this general level of evaluation are planned, with particular emphasis on exploring the origins of isolation, the nature and functions of informal social supports and the factors which enhance the diffusion of support through a network of contacts (Hodgson, 1979).

TABLE 1

Average Number of Close Friends by Length of Residence in the Area

Length of Residence	Number of Close Friends	
	$\bar{x}$	n
< 2 years	3.0	(5)
2 - 3 years	4.7	(4)
3 - 5 years	1.7	(7)
More than 5 years	2.8	(5)

Note: The n is 21 because several women had moved from the area and their answers didn't apply. Others had incomplete data.

TABLE 2

Correlations of Selected Measures with User's Length of Contact with the Child/Parent Centre

	Pearson Correlation r	p (one-tailed test)
1. Number of close friends	.41	~.05
2. I-E Locus of Control*		
1 = internal		
2 = external		
Fate Control Subscale	-.03	-
Social System Control Subscale	.52	<.05
Impulse Control Subscale	.40	~.05
3. Number of Community activities outside the Centre	.45	<.05
4. Number of activities of the children outside the Centre	.37	<.10
5. Special responsibility taken in activities	.46	<.05
6. Depression**	.07	-

Note: The correlations are calculated from data from 16 users for whom length of contact was available who still lived in the area.

* The scale used is described in an article by Schlegel and Crawford and is a shortened and modified version of the Reid and Ware's Locus of Control Scale (1974).

** The CES-Depression scale devised by Radloff (1977) for use with the general population was used.

TABLE 3

Mothers' Physical Health by Length of Contact with the Centre

	Length of Contact			
	Short[a]		Long	
	n	%	n	%
Frequency:				
Number of Illnesses:	14	76%	4	24%
Accidents:	2	50%	2	50%
	16		6	
Seriousness:				
% illnesses and accidents requiring contact with doctor	12 (of 16)	75%	3 (of 6)	50%
% illnesses and accidents requiring hospitalization	3 (of 16)	19%	0 (of 6)	0%

[a] New mothers are 44% of the sample.

TABLE 4

Mothers' Preschool Childrens' Physical Health
By Length of Contact with the Centre

	Length of Contact			
	Short[a]		Long	
	n	%	n	%
Frequency:				
Number of illnesses:	25	63%	15	37%
accidents:	5	83%	1	17%
	30		16	
Seriousness:				
% illnesses and accidents requiring contact with doctor	24 (of 30)	80%	13 (of 16)	81%
% illnesses and accidents requiring hospitalization	15 (of 30)	50%	1 (of 16)	6%

[a] New mothers' preschoolers account for 50% of the sample.

TABLE 5

Spouses' Physical Health by Length of Contact with the Centre

	Length of Contact			
	Short[a]		Long	
	n	%	n	%
Frequency:				
Number of illnesses:	3	38%	4	62%
accidents:	0	0%	3	100%
	3		7	
Seriousness:				
% illnesses and accidents requiring contact with doctor	3 (3 of 3)	100%	7 (7 of 7)	100%
% illnesses and accidents requiring hospitalization	0 (0 of 3)	0%	1 (1 of 7)	14%

[a] Newer mothers' spouses are 42% of the sample and old users' spouses 58% of the sample.

FOOTNOTES

1. This work has been supported by The Hospital for Sick Children Foundation's grant to the University of Toronto to establish the Child in the City Programme. This work has also been supported by two evaluation seed grants to the Child/Parent Centre, one from the Prevention Sub-Committee of the Children's Services Committee of the local Inter-Agency Council and one from the Children's Services Division of the Ontario Ministry of Community and Social Services.

2. It is planned to explore this explanation further in the larger study.

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